Commonwealth of Kentucky

Personnel Cabinet

Department for Employee Insurance

2007 Dependent Drop Form

This form must be used for any qualifying event (QE) that allows you to drop dependents from your plan. (*You must complete a Health Insurance Application to request other coverage election changes such as electing new coverage, option changes, new waiver or to cease a cross reference plan)*

Applicant's SSN

Retiree's SSN (if applicable)

Company Number

Print Name (First, MI, Last) _____

To be eligible to drop a dependent from your health insurance plan, you must certify that you have experienced the QE as listed here.
By signing this form you are also certifying that you are not under any administrative order to cover the dependent(s) on your health insurance plan.

Qualifying Events: (Check one)

- ☐ Divorce*/Legal Separation*/ Annulment*
- ☐ Legal Guardianship/Admin Order/Court Order* +
- ☐ Spouse/Dependent/Retiree's Death
- ☐ Dependent child becomes ineligible
- ☐ Spouse/Dependent gains employer-sponsored Group Coverage*
- ☐ Sp/Dependent ends LWOP* (resumes coverage)
- ☐ Sp/Dep becomes eligible for Medicare*
- ☐ Sp/Dep becomes eligible for Medicaid*
- ☐ Sp/Retiree has a different open enrollment period*+
- ☐ Dependent Care Significant cost increase
- ☐ Other_____

Qualifying Event Date (mm/dd/yy): _____

Note: SP = Spouse DEP = Dependent

** Supporting documentation required*

+Refer to QE chart for redirection rules

NOTE: DEPENDENTS WILL BE <u>DROPPED</u> FROM YOUR PLAN AT THE END OF THE MONTH OF THE SIGNATURE DATE ON THIS FORM.

Exceptions:

- ❖ *Death: dependent will be dropped effective the date of death.*
- ❖ *Ineligible Dependents: ineligible dependents will be dropped from plan at the end of the month in which they become ineligible.*

PRINT the following information for each dependent to be dropped. If dropping self, you must complete a Health Insurance Application.

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Rel.Code **
		M F		
		M F		
		M F		
		M F		

****** Rel. Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent

If your employer does not participate in Commonwealth Choice, contact your Insurance Coordinator for specific information. Retirees are not eligible to participate in an FSA.

<u>Healthcare FSA</u>

I request to change my annual election from $_____ per year to $_____ per year.

<u>Dependent Care FSA</u>

I request to change my annual election from $_____ per year to $ _____ per year.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Applicant Signature _____ Date _____ Insurance Coordinator Signature _____ Date _____

Signatures are required below if changes to an existing cross-reference plan are being requested

Spouse Signature _____ Date _____ Spouse Insurance Coordinator Signature _____ Date _____

ONE COPY – Enrollment Information Branch ONE COPY – Employer/Retirement ONE COPY – Employee/Retiree Revision Date: 03/05/2007